

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. _____

MAY 19 1944 318
Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5332 Delmar Blvd. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Anna Murphy.

3. (b) If veteran, _____ 3. (c) Social Security
name war _____ No. _____

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, Divorced Widow.
6. (b) Name of husband or wife Joseph M. Murphy. 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased May 18, 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>11</u>	<u>23</u>	_____ hr. _____ min.

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home.

11. Industry or business _____

MOTHER FATHER { 12. Name John K.O'Hearn.
13. Birthplace Ireland. 4
(City, town, or county) (State or foreign country)
14. Maiden name Johanna Pierce.
15. Birthplace Ireland. 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Isabel Kersting.
(b) Address 5332 Delmar Blvd.
17. (a) Burial. (b) Date thereof 5-13-43.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery.18. (a) Signature of funeral director Arthur Donnelly & Co.(b) Address 3840 Lindell St.

19. (a) MAY 11 1944 (Date received local registrar)
J. B. Bruneau (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis.
(If outside city or town limits, write "RURAL")
(d) Street No. 5332 Delmar Blvd.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11,
year 1943 hour 5 minute 20 A. M.

21. I hereby certify that I attended the deceased from
April 24 1943 to May 11 1943
that I last saw her alive on May 10 1943
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic myocarditis with
aortic dilatation 5 yrs.

Due to _____

Due to _____

Other conditions Seriously ill
(Include pregnancy within 3 months of death)

Major findings: None
Of operations _____

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
(e) Means of injury _____

23. Signature S. J. Javary (M. D. or other) M.D.

Address 607 W. Grand Blvd Date signed 5-11-43

*Dr J. W. C. Kent - Mr
Barnes 2-3*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,
working under my personal supervision.

Signed: Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Linnell Blvd

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.